REMARKS OF HENRY A. WAXMAN, CHAIRMAN
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TO THE
NATIONAL HEALTH LAWYERS ASSOCIATION
June 12, 1992

Good morning. A few weeks ago, California held a primary. The Kaiser Family Foundation took the opportunity to ask voters what they thought about health care. The poll found that, after the economy, health care was the issue most important to the primary voters -- more important than taxes and more important than crime. And this poll was taken a little more than a month after the tragedy in South Central L.A.

But the poll also found that "while health is alive as an issue, issues, for the moment, are dead." People care much more about character and leadership ability, at least when they're thinking about who to support for President.

Even though California voters may not be interested in issues right now, I'm going to assume that you are and talk about two issues that I think are very much alive: health care reform and health care cost containment.

Health Care Reform

You've probably seen the press about gridlock in the Congress on the issue of health care reform.

I'm sorry to tell you that there's a good deal of truth to these reports. First, let's start with the Republicans. The President has given a speech and issued a 90-page white paper on health care reform. He has done little else other than have Secretary Sullivan attack proposals advanced by various Democrats in both the House and the Senate. And he will certainly veto any bill that raises new revenues or imposes cost controls.

The Democrats want to reform the health care system but have not been able to agree on how to do it. Despite strenuous efforts by the Majority Leader, Dick Gephardt, to find a middle ground, there is at this point no consensus within the House Democratic Caucus. It's my understanding that, in the Senate, the Majority Leader is attempting to fashion a bipartisan agreement on health care reform.

There's been a lot of talk in the press about the absence of "leadership" in Washington. The reality is that, on health care reform, there is also shortage of what John Dingell has called "followership."

Some of my colleagues feel strongly that the country needs -- and the people want -- a radical overhaul of the current system along the lines of the Canadian system.

Others feel that we ought to build on Medicare -- a program that millions of Americans are protected by and satisfied with -- and extend its coverage to the rest of the population.

Others believe that we need to build on our employment-based system by requiring employers to offer basic coverage to all their employees and dependents, either by buying private insurance or by enrolling their employees in a government program.

Finally, some argue that we restructure the tax code to give employers a strong incentive to enroll their employees in low-cost, managed care plans.

I'm not aware of any support for the President's tax credit proposal set forth in his 90-page white paper.

Mr. Gephardt is urging that the Democrats rally around a bill he sees as a middle ground. It won't raise new revenues, and it won't impose any requirements on employers.

It <u>would</u> impose what Mr. Gephardt calls "enforceable" cost containment, as well as insurance market reforms and some modest

expansions in coverage -- expansions paid for by the savings from cost containment.

I would much prefer a comprehensive bill that guarantees basic health care coverage to all Americans. But I recognize that there is not much support within the Democratic Caucus for raising the revenues that will be necessary to extend basic coverage to the uninsured. And I feel strongly that we have to get a handle on health care costs not only so we can bring the uninsured into the system, but also to prevent currently insured Americans from being priced out of the health insurance market and joining the ranks of the uninsured.

So I am supporting the Gephardt proposal, and I am urging my colleagues to do so. Whether a sufficient number will join with the Majority Leader to bring a bill to the floor remains to be seen.

At the same time, I'm working with John Dingell, the Chairman of the Energy and Commerce Committee, to develop a comprehensive plan that uses the Federal government as a single collector of revenues earmarked for basic health care, and gives all Americans access to basic coverage through providers or plans of their choice.

Cost Containment

While issues may be dead right now -- at least for California primary voters -- when they come back to life, health care costs will be right at the top of the list. Like respondents from other States in polls taken recently, California voters are very worried about health care costs -- especially rising insurance premiums and out-of-pocket expenses.

When California voters were asked about their preferences for controlling health care costs, only 11 percent wanted to "leave things the way they are." In short, virtually no one thinks the current system has the capability to restrain health care cost inflation. And, of course, they are right.

What interested me was that 45 percent of the voters said they

preferred "government setting budgets and regulating fees that doctors and hospitals can charge." Only 33 percent preferred the use of "financial incentives that would encourage enrollment in HMO's or other managed care plans."

The greatest support for government regulation of hospital and physician charges came not -- as some of you might be thinking -- from Clinton supporters. It came from Perot supporters. Fifty three percent of those who said they would vote for Perot if the election were held today also said they preferred government setting budgets and regulating fees as the way to control health care costs.

Now I don't mean to suggest that Ross Perot is soon going to announce his intention to impose price controls on the health care sector. But these poll results are consistent with those of national polls I've seen. People are very upset with the rapid growth in the cost of health care, and a significant number of them want government to bring premium and price increases under control.

The Congressional Budget Office now projects that health care premiums paid by employers will increase, on average, about 15 percent a year for each of the next five years. The projected rate of increase in government spending on Medicare and Medicaid is only slightly lower -- about 12 percent a year. Obviously, neither rate of increase is sustainable in an economy that is growing at less than 5 percent a year.

On the private side, many employers facing cost increases of this magnitude will be forced to drop coverage -- first for dependents, then for employees -- adding more Americans to the 36 million uninsured. On the public side, there will be more and more pressure to cut back on Medicare and Medicaid reimbursements -- cutbacks which will result in shifting more costs to private payors, which will in turn result in even more employers dropping their coverage.

My own preference is to give private purchasers -- that is, health insurers, self-administered employer plans, Taft-Hartley funds, and HMOs and other managed care plans -- the option of insisting that

hospitals, physicians, and other providers accept payment at levels determined according to Medicare reimbursement methodologies. Providers who refuse to accept these rates from private purchasers would be excluded from participation in Medicare and Medicaid.

Of course, this approach to cost containment can only work over time if we move toward a system of universal coverage for basic health care services. Otherwise, providers that treat large numbers of uninsured patients will not be able to survive financially without subsidies from some other source.

I don't for a minute believe that this is the ultimate solution to the health cost problem. But it would give private purchasers much more leverage vis-a-vis providers than many of them now have. And I am confident that, in some communities, these purchasers would use this leverage to restrain hospital and physician price increases.

Some of my colleagues are urging that we change the tax code to limit the amount of health insurance premiums which an employer can deduct to the cost of the lowest-cost managed care plan in the area. This, they argue, will give employers the incentive they need to enroll their employees in the most efficient managed care plans. The market, they contend, will take care of the rest, with competition among these plans working to reduce the rate of increase in health care costs.

I have long been a supporter of HMOs. I firmly believe that consumer choice needs to be an essential part of any health care reform, and that plans should compete on the basis of quality and value. However, I don't believe that competition among managed care plans will reduce health care costs.

I know of no evidence that competition among managed care plans has actually reduced the rate of increase in health care expenditures. According to the Congressional Research Service, family premiums for medium and large employers grew 41 percent between 1988 and 1990, while family HMO premiums increased 40 percent. In short, while HMOs might initially yield savings by reducing unnecessary hospital care,

the rate of increase in their premiums is vitually the same as that of conventional insurance plans.

My own view is that we cannot afford to take yet another leap of faith that unleashing market forces through "managed competition" will restrain health care cost increases. Many of you will remember the debate over -- and the defeat of -- the Carter Administration's hospital cost containment legislation in 1979. We decided to give the market -- then known as the Voluntary Effort -- a chance to work. Thirteen years -- and billions of dollars later, it is clear that it didn't.

That's why Dick Gephardt, who led the successful fight against the Carter cost containment measure in 1979, is now pushing hard for an enforceable national health care budget. After 13 years of unrestrained cost increases -- with no end in sight -- he has -- reluctantly, I think -- come to the conclusion that more than competition is needed to control health care costs.

I agree. We need to set up a mechanism that gives private employers and government a reasonable prospect for the health care cost increases will be restrained. That's precisely what extending Medicare payment methods to private payors will do.

Some of your clients may be concerned that this approach will lead inevitably to across-the-board controls on health care prices. I don't think that's necessarily the result. But let's assume that nearly all private purchasers use the leverage to use Medicare rates. As distasteful as that notion may be to some, consider the alternative: doing nothing.

One of the few certainties in the health care sector is that, if we do nothing, things will just get worse. If we leave current regulatory and reimbursement policies unchanged, we will see nothing but continued high inflation in health care costs.

In the private sector, that will lead to more erosion of employer-based coverage, especially among small employers, for whom

affordability is the prime concern. We need to reduce the number of uninsured, not increase them.

In government programs, continued health care inflation will lead to one of two results -- whether or not the Balanced Budget Amendment is enacted.

The first possibility is that more States could adopt the Oregon solution: rationing.

Here's how it works. The State will guarantee providers their full costs and guarantee eligility to everyone below the poverty line. But since it can't reduce provider reimbursement or limit eligibility, the State will have no choice but to make up for any shortfall in revenues by cutting back on the types of treatments it covers.

And, just to be sure that providers are not deterred from rationing care, the State has exempted physicians and hospitals from any tort liability for denying treatments to patients whose conditions are "below the line" and therefore not reimbursable.

A recent article in the Journal of the American Medical Association pointed out that Oregon could save up to $50 million per year simply by reducing the use of hospital beds for discretionary medical admissions throughout the State to the rate in Salem, the State capitol. Unfortunately, reducing the unnecessary use of hospital resources is not how the State has chosen to control costs. Instead, it has decided to set in place a system that will allow them to deny coverage to low-income women and children for services that are medically necessary and appropriate but simply not high enough in priority. Which treatments are covered will depend on how much the State is willing to spend at any point in time.

This certainly isn't my idea of a basic benefit package.

Of course, the ultimate irony about the Oregon rationing experiment is that it will probably be approved by an Administration that vigorously denounces government rationing of health care.

President Bush and Secretary Sullivan have both spoken with great passion about what they see as the evils of government rationing inherent in the "pay or play" and the "single payor" proposals for health care reform. Yet rationing does not get any more governmental -- or any more explicit -- than it does under the Oregon plan.

The other possible response to continued inflation in health care costs is that the Federal government will establish a limit on Federal spending for Medicare and Medicaid. This limit, known inside the Beltway as an "entitlement growth cap," would set a absolute limit on the amount that Federal Medicare and Medicaid spending could grow each year.

Let's assume we set the growth limit at what the Administration wants -- the percentage incease in the eligible population, plus the increase in the Consumer Price Index, plus 2.5 percent. Let's assume that next year that comes to 8 percent. Well, Medicare spending is expected to increase by about 11 percent, and Medicaid by about 16 percent. The difference between the cap and expected growth is roughly $9 billion.

I'm sure I don't have to tell you that the way the Federal government will limit its Medicare spending to achieve these savings. It won't cut benefits to the elderly or disabled, like Oregon is doing to poor women and children. It will cut reimbursement to hospitals and doctors.

The way the Federal government will limit its Medicaid spending is to reduce matching payments to the States. To deal with the shortfall in Federal funding, the States will demand -- and receive -- "flexibility," including a repeal of the Boren amendment and the disproportionate share payment requirement.

The entitlement growth cap is not just another policy fad. It is a deadly serious proposal that has the support of both the Bush Administration's Richard Darman and the Democratic Chairman of the House Budget Committee, Leon Panetta. It was offered and then withdrawn by Mr. Domenici during the Senate debate earlier this year

on the FY 93 budget resolution. And although it is not likely to be adopted this year, it will certainly resurface after the election -- regardless of whether a Balanced Budget Amendment is adopted, and regardless of who wins the Presidency.

The only real alternative to an entitlement growth cap is health care cost containment. Most of the growth in Federal entitlement programs is attributable to Medicare and Medicaid. And most of the growth in each of these programs is caused by the increases in the price of the hospital, physician, and other services that they buy.

Cost containment policies that lower the rate of inflation in the price of hospital and physician services across the board will reduce the rate of increase in Medicare and Medicaid spending.

Without across-the-board cost containment, the only way to limit the increase in Federal entitlement spending is to impose an arbitrary "growth cap." The cap would -- by definition -- limit Federal spending on Medicare and Medicaid. But it would also result in a shift of costs to private insurers and employers, and an increase in costs to poor and elderly program beneficiaries.

Depending on how tight the cap was set over time, this cost shift could be enormous, making health care coverage even more costly for private purchasers. That, in turn, would force even more employers to drop the coverage they now offer, increasing the number of uninsured Americans, whose costs would have to be covered by those who are still privately insured.

It's called a death spiral.

So let's get to the bottom line. From the standpoint of your clients, which is less worse? Health care cost containment or an entitlement cap?

I believe that system-wide cost containment is better option, both for your clients and for the country. If it is properly designed, system-wide cost containment will be a lot less arbitrary and a lot

less divisive than constant budget-driven government reimbursement cuts. Well-designed cost containment can spread the burden of constrained resources more equitably than government reimbursement cuts, which will seriously damage -- and in some cases destroy -- many of the institutions that serve large volumes of Medicare or Medicaid patients.

I know that many of your clients are strongly opposed to government efforts to restrain health care cost increases. But I would urge you to ask them to think very carefully about the alternatives and their long-term consequences -- not just on their institution or their practice, but also on their communities.

And I would ask you to use your creativity to help us design a cost containment strategy that will work. Not because that's anyone's idea of a good time. But because there are no other acceptable choices.

I'd be happy to answer a few questions.